Department of Veterans Affairs

Registration Form

Employee Education System

TITLE OF PROGRAM: **Care Coordination and the Caregiver Forum**

LOCATION OF PROGRAM: **Natcher Conference Center National Institutes of Health**
Building 45, Center Drive, 9000 Rockville Pike
Bethesda, MD 20815 Telephone: 301-496-9966

PROGRAM DATE(S): **January 25-27, 2006**   **PROGRAM NUMBER:** **06.ST.CC.JANCONF.A**

CONTACT PERSON: **Name: Marty Oexner Phone: 314-894-6648 x6247 Fax: 314-894-6506**

Email: martin.oexner@LRN.va.gov

REGISTRATION INSTRUCTIONS

1. Download a copy of this form to your personal computer (under FILE, click on SAVE AS, specify SAVE IN destination on your personal computer, click SAVE).
2. Follow your local approval procedures before registering for this program.
3. Participants from TEMPO II sites must also provide this information to EES to complete course registration.
4. Email or Fax completed registration form to the EES contact person listed above.
5. If travel is required to attend this program, funds must be provided by your facility/VISN.
   - Your travel clerk will need to prepare your travel authority (SF-3036).
   - Obtain your travel authority (SF-3036) and advance of funds.
   - Obtain a traveler's itinerary worksheet from your travel clerk.

REGISTRATION DEADLINE: January 11, 2006

Employee Education Resource Center
#1 Jefferson Barracks Drive
Building 2, Room 114
St. Louis, MO 63125

PARTICIPANT INFORMATION   *(Please type or print clearly)*

Name:	*First*		*MI*	*Last*

SSN*: [   ]   **Sex:** ☐ Male   ☐ Female

Job Title: *(40 spaces max)*

Professional Degree(s): *As it should appear on your certificate* | *(15 spaces max)*

Occupational Category: ☐ Administrative ☐ Associated Health ☐ Physician ☐ Dentist ☐ Nurse

Employer Category: ☐ VHA ☐ VBA ☐ NCA ☐ Other Federal ☐ Non-Federal

Accreditation/Contact Hours Requested: *See program brochure for description of Continuing Education Hours and type of credit offered -* ***You must attend 100% of the program and complete the evaluation to receive credit for your attendance.***

☐ ACCME   ☐ ACHE   ☐ ANCC   ☐ ASWB

Facility/Org Name:		**Facility #**
Mailing Address:		**VISN #**
City / State / Zip:		
Service / Dept:		**Mail Routing Symbol (VA):**
Phone:		**Fax:**
E-mail Address:		**Pager:**

ALTERNATE NAME BADGE: *(If the name and/or organization should be different on name badge, please indicate below)*

Name:	*First*		*MI*	*Last*
Organization:				

While at program, name & number to call in event of an emergency: *(Required)*

Name:	*Day #:*	*Eve #:*

Please describe any special arrangements due to physical limitation(s) and/or special dietary requirements:

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COMPLETE THIS SECTION IF SUPERVISOR APPROVAL IS REQUIRED FOR REGISTRATION

I certify that the funding is available to send the participant to the course, and that the participant has the time available to attend the course.

_____
Participant Signature

_____
Supervisor Signature

_____
Date

_____
Date